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New care home admission following hospitalisation

Citation for published version:

Rhynas, S, Garcia Garrido, A, Burton, J, Logan, G & MacArthur, J 2018, 'New care home admission following hospitalisation: How do older people, families and professionals make decisions about discharge destination? A case-study narrative analysis', *International Journal of Older People Nursing*, vol. 13, no. 3, e12192, pp. 1-11. <https://doi.org/10.1111/opn.12192>

Digital Object Identifier (DOI):

[10.1111/opn.12192](https://doi.org/10.1111/opn.12192)

Link:

[Link to publication record in Edinburgh Research Explorer](#)

Document Version:

Peer reviewed version

Published In:

International Journal of Older People Nursing

Publisher Rights Statement:

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New care home admission following hospitalisation: how do older people, families and professionals make decisions about discharge destination? A case-study narrative analysis.

Journal:	<i>International Journal of Older People Nursing</i>
Manuscript ID	OPN-2017-0925.R2
Manuscript Type:	Original Article
Keywords:	Older People, Care Homes, Decision-Making, risk, Involvement, Narratives

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Review

Table of changes made in response to review comments

Comments – Reviewer One	Changes made to paper
Attribution of feelings to people without clear evidence.	<ul style="list-style-type: none">• ‘miserable’ removed in relation to Frances.
Unproblematic attribution of perspectives to people without speaking to them. (specifically Tom)	<ul style="list-style-type: none">• Phrase from case records added to explanation.• Connection between case record entry and described emotion clarified.
Complex care – ‘support needs too great’	<ul style="list-style-type: none">• Detail from the data added to the explanation.• Family role in making decision clarified.• Specific narrative example of regular care visits added to sentence of explanation.
Limitations – stylistic revision	<ul style="list-style-type: none">• Sentences added to directly refer to attribution of emotions and limitations of case note reporting of emotion.
Conclusion – rewrite into single paragraph	<ul style="list-style-type: none">• Re-ordered to ensure flow of a single paragraph conclusion.

For Peer Review

Abstract

Aims and objectives. To gain an in-depth understanding of the decision-making processes involved in the discharge of older people admitted to hospital from home and discharged to a care home, as described in the case records.

Background. The decision for an older person to move into a care home is significant and life-changing. The discharge planning literature for older people highlights the integral role of nurses in supporting and facilitating effective discharge. However, little research has been undertaken to explore the experiences of those discharged from hospital to a care home or the processes involved in decision-making.

Method. A purposive sample of ten cases was selected from a cohort of 100 individuals admitted to hospital from home and discharged to a care home. Cases were selected to highlight important personal, relational and structural factors thought to affect the decision-making process. Narrative case studies were created and were thematically analysed to explore the perspectives of each stakeholder group and the conceptualisations of risk which influenced decision-making.

Results. Care home discharge decision-making is a complex process involving stakeholders with a range of expertise, experience and perspectives. Decisions take time and considerable involvement of families and the multidisciplinary team. There were significant deficits in documentation which limit the understanding of the process and the patient's voice is often absent from case records. The experiences of older people, families and multidisciplinary team members making care home decisions in the hospital setting requires further exploration to identify and define best practice.

Implications for practice. Nurses have a critical role in the involvement of older people making discharge decisions in hospital, improved documentation of the patient's voice is essential. Health and social care systems must allow older people time to make significant decisions about their living arrangements, adapting to changing medical and social needs.

Key words: older people, care home, decision-making, involvement, risk, narratives

Summary Statement of Implications for Practice

What does this research add to existing knowledge in gerontology?

- Care home discharge decisions in the hospital setting are complex, time consuming and require effective collaboration between the older person, their family and the multidisciplinary team
- Families and professionals are dominant voices in the records of older people and the individual's voice often cannot be heard
- Nursing documentation, in comparison to that of doctors and allied health professionals, often fails to capture the involvement of the older person, despite them having the greatest opportunities for meaningful engagement

What are the implications of this new knowledge for nursing care with older people?

- Nursing documentation should endeavour to record meaningful interactions with older people, including their thoughts, fears and preferences about discharge residency and support them to be involved in the decision wherever possible
- Nurses and other multidisciplinary professionals must appreciate the significant emotional burden of care home discharge decision-making for the families and older people involved

How could the findings be used to influence policy or practice or research or education?

- Findings suggest that exploratory qualitative research to capture the views and experiences of older people, their families and multidisciplinary staff is required to define best practice in care home discharge decision-making
- Health and social care practitioners must ensure older people have time to make significant decisions about their place of residency and systems must support this both in acute and community environments
- Undergraduate multidisciplinary education must demonstrate the value of effective documentation, which allows the patients voice to be heard

Introduction

This paper presents the findings of a case-study narrative analysis about older people admitted from home to an acute hospital in Scotland and discharged to a care home. The data presented forms a sub-study of a retrospective case note review (Harrison et al., 2017) that explored the characteristics, assessment processes and reasons for discharge to a care home.

Background

Admission to a care home is a significant life event for the individual and their family that is likely to shape the remainder of their lives (NICE, 2015). 20% of those aged over 85 years in the UK (British Geriatrics Society, 2011) and 30% of those of the same age in Canada (Minister of Industry, 2012) reside permanently in care homes. Internationally, demand for care home places is rising as the population ages (Australian Institute of Health and Welfare, 2012). Care home residents typically have complex healthcare needs, reflecting multiple long-term conditions and frailty (Gordon et al., 2014). The terminology and components of care used to describe care home settings varies internationally (Sanford et al., 2015). In this paper the term care home denotes a long-term care facility with nursing services.

Although it is recognised that early discharge planning results in improved outcomes for patients (Fox et al., 2013), significant challenges exist in practice. Staff describe feeling pressure from conflicting roles in the hospital and concern that the urgency to discharge people can leave patients ‘systematised’ without scope to individualise practice (Connolly et al., 2009). Nurses describe feeling ignored and even ‘invisible’ in discharge planning processes (Atwal, 2002, Nosbusch et al., 2011), meaning their ability to advocate for their patients is lost. Furthermore, patients can feel excluded from active decision-making, with evidence of different priorities from patients and staff (Huby et al., 2007).

Cognitive impairment and dementia are prevalent amongst those who are discharged from hospital to care home (Harrison et al., 2017) and this adds to the complexity of decision-making. Decisions about care home admission are recognised to be difficult for everyone, balancing competing individual health and social needs with those of carers, therefore healthcare professionals have a key role in supporting decision-making (Lord et al., 2016). There is a body of international research which explores care home admission in people with dementia living in the community (Beerens et al., 2015, Verbeek et al., 2015, Bleijlevens et al., 2015). By comparison the experiences of older adults admitted to a care home following hospital admission lacks empirical research. Decisions made as hospital inpatients may be

prompted by a crisis and important external factors such as funding, pressures on primary care and availability of home care, influence individual outcomes (Taylor and Donnelly, 2006).

Given ongoing projections of the growing population of older people with multiple comorbidities the pressure on both the hospital and care home sectors in many countries are likely to increase. Effective discharge decision-making is a priority for older people, families, practitioners and policy-makers. Nurses have a crucial role to play in enabling individuals and their families to contribute to the decision-making process, assessment of need and planning transitions.

Aims and Objectives;

The aim of this study was to gain an in-depth understanding of the decision-making processes involved in the discharge of older people admitted to hospital from home and discharged to a care home, as described in the case records. The objectives included examining the:

1. perspectives and involvement of the older person
2. role, perspectives and involvement of family members
3. role, perspectives and involvement of healthcare professionals

Study Design

This study selected ten examples from a larger study of 100 case records of people newly admitted to care home following admission to a teaching hospital in Scotland between November 2013-February 2015. Harrison et al., 2017 report the full detail of the larger study dataset. Descriptive statistical analysis of the complete dataset described the social, functional and cognitive characteristics of the individuals and identified variations in the decision-making process with respect to assessment, involvement and reasoning (Harrison et al., 2017). To explore these variations, ten case records were purposively sampled for detailed qualitative analysis using a narrative research design (Koch, 1998; Labov, 1997). The research team included nursing and medical staff with clinical and research experience of the sample population, all of whom had engaged with the wider study findings. Sampling for this narrative study was based on consideration of relationships, social situations and views that emerged from the larger case note review (Harrison et al., 2017) and were seen to contribute to decision-making. The personal, relational and process factors are outlined in Table 1.

Table 1 Important contributors to the discharge decision-making process identified from case note review which shaped narrative case study sampling

Ethical Approval

The National Research Ethics Service approved the study (REC 14/44/1092), confirming that informed consent was not required from those whose records were included. Approval from the Caldicott Guardian (Health and Social Care Information Centre, 2015) was obtained as well as local management authorisation through internal clinical governance processes.

Data Collection

Ward based case records included entries by nursing, medical and allied health professional staff along with other professionals such as social workers and psychologists. Each set of case records was examined in detail by two researchers, experienced in writing and interpreting such records (SJR, AGG). Case records are, by their nature, a series of reports of interactions, professional views, assessments and factual information. These documents are usually the only written record of a hospital stay, yet material contained within the case records may not fully represent the experience of individual patients or the interactions between patients, staff and families. Many interactions occur which are not recorded and the written information may only represent a single view or selective report of the encounter. However, case records remain a rich source of data from a range of contributors and can allow interacting views and information to come together in a collated account of a hospital admission.

Each older person’s story was written into a narrative including detail of the hospital stay, interactions between staff, older person and family members, multidisciplinary meetings, assessments and the eventual discharge. The process of moving back and forth through the often weighty case folders, collating information from a range of sections and voices, emphasised the value of creating a narrative in order to explore the meaning of the case record. Constructing a narrative account involves a level of interpretation as the account is narrated by researchers who have brought together the range of voices to create a new entity (Ricoeur, 1981). This creative process produces a narrative account which is grounded in the human experiences of those involved while also forming a dialogue with the researchers (Frid, Ohlen & Bergbom, 2000) and in this study, exploring in more detail some of the findings emerging from the wider case note review. The production of the narratives

allowed the researchers to explore, debate and interrogate the range of views expressed and to explicitly consider the views of different stakeholders who are recognized to have potentially different viewpoints (Huby et al., 2007) along with structural constraints of the discharge decision-making process.

An overview of the case studies with their pseudonyms is provided in Table 2.

Table 2
Summary of case study narratives

Data Analysis

Holstein and Gubrium (2012) suggest that narrative research approaches have gone beyond the analysis of personal stories to include complex narratives which incorporate a range of contributors and contexts. The context surrounding individual decision-making about care home admission and the reported voices of patients, professionals and family members in the narrative accounts demonstrate this complexity. The narrative accounts were analysed by the two researchers (SJR, AGG) in three stages: firstly, overarching themes emerged which highlighted the different ways in which each stakeholder group engaged with the discharge process. Secondly, the perspectives of the older person, adult children and healthcare professionals were specifically identified and explored. Thirdly, the notion of risk pervaded the case records and was particularly evident in the language of family members and professionals and, to a lesser extent, patients. Therefore, different conceptualisations of risk were explicitly examined providing insight into the complex decision-making associated with the move into a care home.

Results

The older people, family members and professionals all brought different perspectives, expertise and emotions to this life changing decision. The following sections present extracts of the researchers' narrative accounts to outline the findings from the perspectives of each stakeholder, examining themes influencing decision-making.

Perspectives and involvement of the older person

Older person's wishes regarding care home admission

The study sample included individuals who had chosen to go to care home and those who wanted to be discharged home. Edith wanted to be 'looked after' as she no longer had

confidence to manage alone, a view which she expressed strongly despite professional and family opposition to her care home request.

She returned from her OT home-visit saying that she's not going home and would prefer to stay in hospital and be looked after. She worried specifically about having to collect her own medication from the local pharmacy and was concerned about the risk of falling. Edith repeatedly asked to be 'looked after'. (Edith)

Edith was given time and encouragement to regain her confidence and practice skills which may have allowed her to manage in her own home. However, her wishes were fulfilled and she was admitted to a care home at the end of her four-month hospital admission.

For Frances and Mary, the idea of never returning home was a source of distress and anxiety. Frances lived with her daughter and sought a lot of attention from her surrounding family. She had capacity to make health and welfare decisions, yet her voice was difficult to discern from the records. The case records suggested that decision-making processes focused on Frances' psychological support needs, withdrawal of intensive family support and her psychologist's documentation of her wish to return home. Mary lacked capacity to make health and welfare decisions and her voice was largely absent from the case records. However, her wish to return home was clearly communicated by her family.

Family are concerned about her safety – 'not coping at home' - worried that she neglects herself, doesn't wash, has compromised nutrition, has trouble cooking and has been found wandering outside. Care home recognised as being necessary, funding secured and plans in place. Then an entry with her daughter asking what would need to be done to keep her at home – obviously still a hankering for home even when plan looked clear. (Mary)

This extract demonstrates the role of family as advocates, expressing Mary's wishes separate from their anxieties. It also highlights the significance of the decision and the extent to which family members can be torn by conflicting wishes. Those who did not have family to act as advocates did not enjoy such detailed consideration of their preferences in the documentation, although the influence of such documentary evidence of views on the decision-making process requires explicit exploration in future research. The absence of a family member limited the depth of discussion about the ultimate discharge destination. This was the case for Archie whose lawyer and neighbour arranged for his transfer to a care home with minimal documentation of his preferences or of the relative merits of other potential discharge destinations.

Complex Care Needs

Despite expressing a strong desire to go home, for Sandy, Alasdair and Alice their support needs were considered by their families to be too great. Sandy experienced challenging behavioural and psychological symptoms of dementia and he and his wife agreed that discharge to a care home was the right decision. For Alasdair and Alice their records

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3 detailed complex physical care requirements including enteral feeding, regular pressure area
4 and continence care. Although these needs can be managed in the community, for them and
5 their families, the possibility of spending long periods of time alone and needing care visits
6 multiple times each day, precluded discharge home.
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9 10 *Unforeseen Circumstances*

11 Unforeseen circumstances played a significant role in the discharge planning for two
12 individuals. Alasdair was awaiting discharge home when his main carer, his wife of seventy
13 years, died. This tragic change in circumstances led to care home admission. The case
14 notes reflect a sensitively handled transition with family and patient being well-supported to
15 address the change. Tom's discharge to his sheltered house was planned until the complex
16 became uninhabitable after a flood and had to be permanently closed.
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20 Notes reflect discussion between patient and consultant about why he is still in hospital. Tom
21 understands that he is trying to improve his walking for going home, not good enough on his
22 feet to go home yet. His ideal solution is to have some carers in his own home to help him get
23 up in the morning. ... Patient's flat flooded, unable to return home, whole complex being shut
24 down. Patient understood perfectly, visibly upset, says he'll 'slit his throat'. Rehousing
25 arrangements are proposed including a place in XX House. Tom seems to understand XX House
26 to be a sheltered housing complex like the one he left. OT and PT assessments state that Tom is
27 fit for discharge to sheltered housing. XX House is actually a care home. Tom felt upset and
28 misinformed. He feels that he has been misinformed since admission when a member of staff
29 told him his hospital stay was likely to last only overnight. (Tom)

30 Tom was involved in decision-making but did not feel fully informed. His upset was clear
31 from both his documented refusal to speak further to staff and his phrase 'they've tellt [told]
32 me anything', offered by way of explanation for his refusal to speak to care staff. His words,
33 quoted in his case records, suggest that he felt powerless to change decisions which were
34 being made for his future and the records did not offer evidence to explain why the decisions
35 were made. This highlights the challenge associated with using case records to explore
36 decision-making as documentary evidence may selectively report interactions or may omit to
37 fully record decision-making processes. These omissions limit the transparency of decision-
38 making, leaving questions around the roles of professionals and the inclusion of older people
39 and their families.
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45 Individual ability to engage in decision-making varied. Some personal wishes were clearly
46 presented by individuals, their families and professionals. Others' wishes were less clearly
47 articulated or were not well incorporated in decision-making. In some cases, care needs
48 pointed to the decision to admit to care home and for others, dramatic changes of
49 circumstance were influential in shaping this life changing decision.
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Roles, Perspectives and Involvement of Family Members

Internationally, adult children live with the conflicting demands of their family and occupational commitments and the care needs of ageing parents. Increasing dependency in an older person may change the nature of the parent-child relationship. Adult children's contributions to decision-making were significant in determining the discharge destination of older people leaving hospital.

Risk and coping

Determining the risks of discharge home and the older person's ability to cope emerged in several case studies. The families of Jean, Frances and Edith expressed worries about the risk of their mothers' falling and potentially lying on the floor for extended periods before being found. Care homes were seen to offer a solution, alleviating the risks and taking responsibility for maintaining safety away from family members. For families such as Mary's, the risk was less about falling and more about more general abilities to cope with tasks at home.

Mary's daughter is shocked at the deterioration in her mental state. Stark contrast with her mum being at home, doing own cooking, cleaning and looking after herself. Family acutely distressed that mum has changed so dramatically, panic that this is not normal and that she won't now manage at home.... 4 days later in the case notes ... 'in view of family concerns may need 24 hour care'. (Mary)

These concerns were taken seriously by staff and a plan started to emerge to discharge Mary to a care home. It was not clear whether family members were aware that their expressions of concern were so directly linked to this decision. This highlights the difficulties in ascertaining how contributions from patients and family members are valued and how narratives compete in the decision-making process. Family members' views were consistently taken seriously by multidisciplinary professionals and the language of risk was both easily understood and readily used by both family members and professionals seeking to justify their decision-making. Often during the early part of an admission the views of family members predominated in comparison to an absent voice of the older person. In many of the case records, this dominant 'voice' was maintained in records of formal meetings and conversations between relatives and staff. Many of these conversations centred on discussions of functional abilities, risk and safety concerns associated with discharge home.

'The final straw'

In a number of the case studies, the family view had been clear from the point of admission and the case for discharge to care home started to build from the emergency department records onwards. This was often presented as the 'final straw'; a situation which heralded

the end of long periods of intense family support. Some families highlighted that situations at home had been precarious for some time and an acute event such as a fall and resulting admission was needed for everyone to see things had become untenable. Frances' daughter highlighted the difficulties associated with balancing the needs of her teenage children with the care of her mother, a balance which challenges many adult children.

Families who saw the admission as a 'final straw', presented compelling evidence in support of their perspective. In the case of Frances the family used language to objectify the home situation, limiting the emotion of the report and strengthening their argument;

Mum is low in mood, she is withdrawn. ... She's not coping at home. ... Mum needs more ongoing support. (Frances)

Using more objective language serves to distance the family from the personal reality of the fragile home situation. This use of language makes the exchange less emotive, protecting Frances' daughter from an emotional exchange about how her mother feels while also allowing her to seek care home placement for her mother and relinquish some caring responsibility in a socially acceptable way.

Rationalizing the decision to seek care home placement was important to family members. Reasons such as their parent's care needs being too extensive to be met at home (Billy, Jean, Mary and Alasdair); the geographical distance between them and their parent being too great to provide regular support (Tom), were ways in which family members rationalized their decisions.

Making the Decision

The adult children of Billy, Jean and Mary struggled with the decision that this was the right time for their parent to consider care home. They highlighted the difficulty of reconciling current care needs with the earlier wishes of their parent. Jean had explicitly expressed a desire to remain at home, so her children found the move to care home particularly problematic and went to considerable lengths to make adjustments to their own lives and homes to avoid this.

Dichotomy between son wanting to uphold mum's wish to go home and the multidisciplinary team (MDT) view that she is not able. Son wants his Mum home but his Mum continually states she's unable to manage individual tasks – washing etc. Jean tells her son she is terrified to go to a care home – he's trying hard to uphold her wishes, against the MDT advice. House renovations were made but as time passes Jean's frailty increases. Family members aware that this is a 'landmark' decision. Son is concerned about 'committing' his Mum to a care home when she always wanted to stay at home. He tearfully reports that he 'wants to be a good son and uphold his Mum's wishes' but later expresses concern about how the family will manage. (Jean)

Explicit in this example, the concept of trying to meet social expectations of the relationship between parent and child pervaded many of the case records. Adult children articulated feelings of guilt, frustration and distress as they tried to reconcile the previous wishes of their parents, their own commitments and the reality of current care needs. The clear message was that the decision was not considered lightly by family members who struggled with the changes to their roles and relationships and the perceived finality of the care home decision.

Roles, perspectives and involvement of healthcare professionals

Contributions to decision-making

Care home discharge decisions were made during interactions with the patient and family, discussions in multi-disciplinary meetings and formal case conferences. Given the time pressures in the healthcare systems internationally, it was interesting to note the time taken by MDT members to discuss discharge options and await clinical improvement. In Jean and Mary's cases their families were given periods in excess of 30 days to adjust to the decision and in none of the case studies was there evidence of time pressure influencing the outcome.

It was often difficult to discern from the case records how involved the older person was in decision-making. Good examples were those, mainly written by medical staff, which reported verbatim quotations from discussions with the older people, allowing their voices to be clearly communicated. Allied health professionals produced useful accounts of assessments which contributed to the evidence base for decision-making. Nurses have a great deal of access to fellow professionals, patients and family members and opportunities to discuss discharge plans, influence decision-making and record the opinions of stakeholders. Overall record keeping of such engagement and contribution to decision-making by nurses was limited and decision-making interactions remained invisible to the study because of incomplete documentation.

Strength of professional continuity

In Sandy's situation the family's community social worker maintained involvement in his case during the hospital admission. This involvement strengthened and streamlined the decision-making process as information from the past was fed directly into the decision-making and duplication of assessment was avoided; there was no need to review home circumstances or carry out home assessments because information was readily available through the

community social worker's involvement. Consequently the decision to admit Sandy to a care home was swift and clear, saving both stress and resources.

Risk Narratives

Professionals often used the language of risk to strengthen their case for care home discharge. In some cases it was linked to their professional duty of care, which brought a formality to the language and suggested a statutory cause for the decision. For example, Jean's case record entry included;

Nurse explained 'It would be 'neglect' to send her home when needing so much care. It would be against my duty of care'. (Jean)

Reference to risk also created a sense of distancing and objectification of the person's situation, particularly when professionals discussed abilities within the home. They did not specify examples of being unable to undertake domestic tasks but rather described the home situation as '*precarious*' (Archie and Jean) or used phrases such as '*not coping at home*' (Sandy) and '*socially isolated*' (Tom) to summarise a range of complex domestic situations. This language served both to objectify the individual's circumstances and also to sideline that individual in the decision-making process, silencing their contribution through the use of language associated with risk.

The notion of 'failed discharge' was made explicit in the case studies, linking closely to the concept of risk. In Jean's situation she had had recurrent admissions over the previous year so the MDT advised care home admission. Her hospitalisation was described by some professionals as a 'failed discharge'; a previous failure to make appropriate decisions and provide services to keep her safe and, as such, was viewed negatively by professionals. The study showed that MDT members made every effort to ensure that discharges were risk assessed and every case study included reference to assessments of physical and occupational abilities which could enable successful home discharge. Edith was offered a 'trial discharge' which was viewed as beneficial even if the result was ultimately readmission. She was readmitted after a short stay in her house and was unwilling to go home thereafter as she had lost confidence. However, Edith needed the last visit home to recognise this and the well documented rationale for the 'trial discharge' ensured that this episode was not viewed as a professional failure.

Discussion

This study has explored the decision-making process involved in ten people discharged to care home. Examples of good practice both in documentation and in discharge planning were identified. Time was taken to allow patients to reach their rehabilitation potential before

care home decisions were made and there was no evidence of decisions being made as a result of health service pressure. There were some excellent examples of communication with relatives.

MDT members who quoted the patient's words in their recordkeeping produced accounts which captured the individual's voice and offered greater insights into the decision-making than descriptive entries. Assessment documentation by allied health professionals also clarified some of the practical realities which shaped decision-making. Nursing documentation rarely reported any discussion with a patient about discharge plans. Nurses have a privileged position with both access and opportunity to establish relationships with older people and their families. This position needs to be positively exploited so that nurses take every opportunity to discuss, and crucially to record discussion of, individual preferences and discharge planning conversations. In common with previous research about nursing documentation and the implications for comprehensive geriatric assessment (Charalambous and Goldberg, 2016) poor documentation means that nursing insights and patient interactions were both unavailable to fellow professionals viewing the case records and to the research.

The voice of the older person either in documentation or their involvement in discharge planning, was highlighted as a significant omission in this study. Case notes can only report interactions which professionals choose to record. Competing narratives may serve to limit this recording or may influence the nature of the recording or its use in decision-making. However, in eight of the case study narratives it was difficult to find the voice of the older person at all. The absence of the older person's voice in a decision which is life changing is a significant finding which has been described in inpatient settings previously concerning healthcare needs (Dyrstad et al., 2015). Irrespective of the individual's capacity to make decisions about their health and welfare, legal frameworks applied in Scotland, make clear that they should be involved in decision-making and have their views heard (Cross-Party Group in the Scottish Parliament on Alzheimer's, 2009). Furthermore, optimum involvement in decision-making amounts to more than simply documenting conversations and challenges healthcare professionals to attend to the voices of older people at every opportunity.

It is recognized that person-centred approaches have the potential to improve care experiences (Pope 2012) and ensure patient voices are prioritised (National Voices 2017). With the availability and increased awareness of person-centred practice frameworks (McCormack & McCance 2017), it is reasonable to expect that the person be central to

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3 decision-making about discharge destination wherever possible. McCormack and McCance
4 (2010) suggest that understanding of how person-centredness is operationalised remains
5 underdeveloped and this study adds to this claim, specifically asserting the need for further
6 exploration of the concept of person-centred discharge and the role of family members and
7 professionals in shaping and facilitating approaches to discharge which are centred around
8 the individual.
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14 **Risk**

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16 The concept of risk was a pervasive discourse in making a case for care home admission.
17 Understandings of risk are shaped by an older person and family's background,
18 experiences, personality, education and relationships, as well as by professional
19 perspectives and roles. Differing understandings of risk between professionals, patients and
20 family carers are well established (Clarke, 2000; Mitchell & Glendinning, 2007; Clarke et al.,
21 2010) and these colliding perspectives shape planning for care home admission. Risk
22 assessment and management are understood to be central to professional practice in
23 healthcare (Manthorpe et al., 1995; Alaszewski et al., 1998) and are influential determinants
24 of decision-making, specifically influencing discharge destination (Atwal et al., 2012).
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31 This study found risk and the language of risk shaped decision-making in each of the ten
32 case studies. Functional ability, behaviour and the potential for accident or incident were
33 explicitly discussed as part of every discharge decision. The language of risk was often used
34 by professionals and family members to represent their perspective, influence discussion
35 and support their case for care home admission. In most cases the voice of the older person
36 struggled to be heard against these stronger discourses.
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41 There were no examples in which the risks associated with care home admission itself were
42 explicitly discussed although a number of case studies highlighted difficulties for family
43 members who felt that they should adhere to their parent's previously stated wish to remain
44 within their own home. While some records noted the older person's desire to remain at
45 home, none of the records discussed the potential limitations on independence or lifestyle
46 which ultimately result from care home admission (Davies, 2001). These risks, while not life
47 threatening, are certainly life changing and form a tacit backdrop to decision-making rather
48 than becoming an explicit focus for transparent discussion.
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Decisions are not taken lightly

Encouragingly care home discharge decisions were not taken lightly by professionals or family members. In many cases significant time was allowed for family decision-making and staff took time to assess older people and help them develop skills for discharge. Family members found the decision-making challenging and the case studies highlighted their indecision and anguish in making this life-changing decision for ageing parents. Personal, familial, professional and societal expectations are hugely challenging, not least because they often conflict with each other. One observer may consider it to be neglectful to leave an older person in their own home, running the risk of falls or inability to care for oneself while another may consider the transfer of an older person from their home to the perceived safety of a care home against their expressed wishes to be equally inhumane. In reality, these decisions are made within the context of the family and their individual and collective understandings of risk, their financial context, support networks and competing family demands. Whatever decision is ultimately reached, the evidence from this study suggests that there is significant emotional cost to relatives associated with the decision-making process.

Reconceptualising 'failed discharge'

Early readmission, often termed 'failed discharge' is seen to reflect poorly on the team who discharged the patient home (Cornwell et al., 2012). However, the evidence from this study suggests that there may be some room for reconceptualising 'failed discharge'. A discharge to care home, which prioritises patient safety, has the potential to miss the deeply personal importance of home and risk-taking to some individuals. A person-centred approach to discharge may allow further discussion of individual concepts of safety and risk. Many families and older people talked about the possibility of a 'last chance' at home, a final attempt to hold onto independence for a short period of time. The value of a 'last chance' is impossible to quantify. For some it could doubtless lead to a potentially dangerous or distressing fall or some greater harm. For others it could be an invaluable chance to say goodbye to the family home and form part of the transition to care home and the next chapter of their lives. Reconsidering the way that 'failed discharge' is understood within a person-centred healthcare system may have the potential to allow some older people to enjoy a smoother transition to care home.

Limitations

This study is limited by its reliance on case records as these only permitted the research team access to those accounts of interactions and experiences that were documented. While these records offer significant insights, it is assumed that many other unrecorded

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3 conversations will have taken place. The explicit influence of documented discussions and
4 points of view in the decision-making process can also be difficult to determine from the case
5 records. The construction of a narrative portrait from case records was a methodologically
6 interesting approach and one which allowed the nurse-researchers to discuss and debate
7 issues as they emerged. However, the creation of narrative accounts in this way has the
8 potential to have incompletely represented some aspects of individual cases. Emotional
9 responses from patients and family members were often found in directly quoted phrases or
10 accounts of conversations. The accounts were written by staff who chose to record those
11 details and prioritise specific phrases in their record keeping. By their nature case records
12 represent only highlights from the activities and conversations within the healthcare setting.
13 The research team could only access information about mood and emotion as it was
14 represented in those case records and through the voices of those staff who contributed to
15 the record keeping. Finally, the study is limited by lack of access to those additional records
16 held by the hospital social work team who do not always contribute to unitary patient
17 records.
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28 **Conclusion**

29 The decision to discharge a person from hospital to a care home is significant. The ten case
30 studies demonstrate that it is a complex process involving stakeholders with a range of
31 expertise, experience and perspectives. There is a need for a transparent process which
32 involves collaboration between older people, their families and multidisciplinary
33 professionals. While case records identified examples of good practice, there were
34 significant deficits in documentation which limit understanding of the decision-making
35 process. Only through documentation of deliberate and focused engagement with patients
36 and their families can professionals ensure that care home discharge decision-making takes
37 account of both patient and family wishes. The study has shown that all participants in the
38 decision-making process take the decision seriously but there is considerable emotional cost
39 to some family members. Healthcare professionals need to be more aware of this to more
40 effectively support and understand family perspectives in care home placement. Finally,
41 while this research has offered insights from case records further research is required which
42 explores the views of older people, their families and multidisciplinary professionals. Further
43 work is also required to explore the concept of person-centred discharge and to explore the
44 potential that person-centred practices have to improve the transition between hospital and
45 care home.
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Table 1. Important contributors to the discharge decision-making process identified from case note review which shaped narrative case study sampling

Personal factors	Relational factors	Process factors
<ul style="list-style-type: none"> • Older person wants to go to care home • Older person wants to go home • Older person experiences delirium during admission • Older person has significant unmet care needs 	<ul style="list-style-type: none"> • Family want older person to go to care home • Family want older person to go back to own home • Older person with no family - next of kin lawyer 	<ul style="list-style-type: none"> • Community social worker remains involved during hospital admission • Good communication between multi-disciplinary team (MDT), older person and family • Significant delay during admission and discharge

Table 2
Summary of case study narratives

Case	Age (years)	Care package on admission (x daily)	Summary of situation (Reason for admission, family situation, decision for discharge to care home)
1 Billy	79	No services	<ul style="list-style-type: none">• Complex medical history including diabetes, sepsis, fluid overload, pain, alcohol withdrawal, delirium.• Stroke during admission.• Good support from daughter at home.• Daughter takes on power of attorney and agrees care home needed.
2 Tom	79	1x at lunch	<ul style="list-style-type: none">• Falls. Mild disorientation.• Family live in 2-300 miles away.• Ready for discharge back to sheltered accommodation but flood damage makes home uninhabitable. Place in care home becomes available before another sheltered flat.
3 Jean	83	4x	<ul style="list-style-type: none">• Falls, dehydration, delirium.• Maximum package of care but still precarious home placement.• Family keen to keep her at home but care needs too great.
4 Mary	85	2x	<ul style="list-style-type: none">• Falls. Mixed dementia. Increased confusion during admission.• Family very concerned about ability to manage at home.• Long admission while care home is chosen by family.
5 Archie	94	No services Neighbour helping	<ul style="list-style-type: none">• Leg ulcers, reduced mobility. Fall at home resulting in lying on toilet floor for several hours.• No immediate family. Neighbour anxious about him going home.• Lawyer (formal next of kin) and neighbour arrange care home placement.
6 Sandy	81	No services, wife is carer	<ul style="list-style-type: none">• Dementia, delirium, urinary tract infection.• Community social worker and wife agree care home is necessary.
7 Frances	83	Once weekly bath/shower	<ul style="list-style-type: none">• Fall.• Lives with daughter and her teenage children.• Daughter finding caring role challenging and seeks care home admission.• Depression diagnosed during admission, potentially linked to concerns about going to care home.
8 Alasdair	88	3x	<ul style="list-style-type: none">• Dementia and stroke.• Returned to preadmission level of function and ready for discharge but wife dies suddenly.• Care home agreed by person and family.
9 Alice	82	No services	<ul style="list-style-type: none">• Major stroke. Sudden change in functional ability and significantly increased dependency.

			<ul style="list-style-type: none"> • Family already have substantial caring roles. • Care home agreed by family and professionals.
10 Edith	78	No services	<ul style="list-style-type: none"> • Falls. • Anxious about going home despite being documented fit for discharge home within first week. • 100+ day admission. • Person chose care home discharge despite family and professionals' view that discharge home preferable with package of care.

For Peer Review